Growth Hormones

Member and Medication Information (required)	
Member ID:	Member Name:
DOB:	Weight:
Medication Name/ Strength:	Dose:
Directions for use:	

Provider Information (required)		
Name:	NPI:	Specialty:
Contact Person:	Office Phone:	Office Fax:

FAX FORM AND RELEVANT DOCUMENTATION INCLUDING: LABORATORY RESULTS, CHART NOTES and/or UPDATED PROVIDER LETTER TO 855-828-4992

Please identify the indication and medication: *(Preferred Products are in **bold**)*

Pediatric Indications *(17 years of age or younger)*									
Growth Failure secondary to Chronic Kidney Disease				Nutropin AQ					
Growth Hormone Deficiency	**Genotropin**	Humatrope	**Norditropin**	Nutropin AQ	Omnitrope	Saizen		Zomacton	
Idiopathic Short Stature	**Genotropin**	Humatrope	**Norditropin**	Nutropin AQ	Omnitrope			Zomacton	
Prader-Willi Syndrome (PWS)	**Genotropin**		**Norditropin**		Omnitrope				
Short Stature associated with Noonan Syndrome			**Norditropin**						
Short Stature Homeobox-containing Gene (SHOX) deficiency		Humatrope						Zomacton	
Small Gestational Age (SGA) failed to catch-up growth by age 2	**Genotropin**	Humatrope	**Norditropin**		Omnitrope			Zomacton	
Turner Syndrome	**Genotropin**	Humatrope	**Norditropin**	Nutropin AQ	Omnitrope			Zomacton	
Adult Indications *(18 years of age or older)*									
Growth Hormone Deficiency	**Genotropin**	Humatrope	**Norditropin**	Nutropin AQ	Omnitrope	Saizen		Zomacton	
HIV patients with wasting or cachexia						Saizen	Serostim		
Short Bowel Syndrome									Zorbtive

Criteria for Approval:

- ❑ Medication is prescribed by or in consultation with a physician who specializes in the disease treatment
- ❑ Must not have active malignancy
- ❑ Documented diagnosis of requested indication. Chart note #: _____

Additional Criteria for HIV-Associated Wasting or Cachexia:

- ❑ Must be given by or in consultation with HIV specialist
- ❑ Diagnosis of HIV with wasting or cachexia syndrome. Chart note page #: _____
- ❑ Must be taking antiretroviral medications. Chart note page #: _____
- ❑ BMI < 20. BMI: _____ Chart note #: _____
- ❑ Must not have any untreated or suspected systemic infection or persistent fever > 101 F during the 30 days prior to evaluation of weight loss.
- ❑ Must not have any signs or symptoms of gastrointestinal malabsorption or blockage unless on total parenteral nutrition.
- ❑ Rule out hypogonadism, opportunistic infection, diarrhea, inadequate nutrition intake, malabsorption, and thyroid abnormalities related to muscle wasted.
- ❑ Trial and failure of, or contraindication to a preferred appetite stimulant.
  Medication: _____ Chart Note Page #: _____
  Dates of therapy: _____ Details of Failure: _____

Additional Criteria for Idiopathic Short Stature:

- ❑ Height standard deviation score (SDS) < -2.25
- ❑ Pre-pubertal when therapy is initiated

Additional Criteria for Prader-Willi Syndrome:

- ❑ BMI ≤ 40. BMI: _____ Chart note #: _____
- ❑ No history of sleep apnea, upper airway obstruction, or unidentified respiratory infection. Chart note #: _____
- ❑ Ongoing monitoring for weight control and signs of respiratory infection

Additional Criteria for Short Bowel Syndrome:

- ❑ 18 years of age or older
- ❑ Trial and failure of at least one preferred agent from all of the following drug classes:
  - Proton Pump Inhibitor: _____ Details of failure: _____
  - H2 Antagonist: _____ Details of failure: _____
  - Antidiarrheal: _____ Details of failure: _____
  - Octreotide: _____ Details of failure: _____

Additional Criteria for Small for Gestational Age that fail to manifest catch-up growth by age 2: *(max covered time period is 2 years)*

- ❑ 2 years of age or older
- ❑ Diagnosis of small for gestational age. Chart note #: _____

Non-Preferred Product: *(Criteria above must also be met)*

- ❑ Trial and failure of preferred Growth Hormone Therapy, per Utah Medicaid's PDL, or prescriber must demonstrate medical necessity for non-preferred product.
  Medication: _____ Chart Note Page #: _____
  Dates of therapy: _____ Details of Failure: _____

Re-authorization Criteria:
Updated letter with medical justification or updated chart notes demonstrating positive clinical response.

Authorization: Up to six (6) months
Re-authorization: Up to one (1) year

PROVIDER CERTIFICATION
I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

_____ _____
Prescriber's Signature Date